JS Medical Practice

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CONFIDENTIAL HEALTH QUESTIONNAIRE – ADULT

PLEASE COMPLETE FULLY

OFFICE USE ONLY

Receptionist initials: POA/ID: Yes No

GMS1 Check: - NHS Number ☐
- Previous GP ☐
- Town/Country of birth ☐
- Date of entry in UK ☐
- Sign and Date ☐
- Interpreter ☐

New Patient Check

Appt with **HCA/Practice Nurse/Sharon**

Date:..... **Time**: .....

JS Medical Practice does not discriminate on the grounds of:

- Race, gender, social class, age, religion, sexual orientation or appearance
- Disability or medical condition

Please take the time to fill in this questionnaire so that we can provide you with the best service. Once completed please return to the JS Medical Practice reception.

Name: ..... D.O.B.:.....
Address: ..... Home Tel:.....
..... Mobile:.....
Post code:..... Work Tel: .....

Sex: Male ☐ Female ☐

Marital status:
Single ☐ Married ☐ Cohabiting ☐ Separated ☐ Divorced ☐ Widowed ☐

Ethnicity:
Please state your ethnicity, e.g. White British; Black British; Asian Indian; White Polish; Chinese

.....

Languages spoken:.....

Occupation:
Employed ☐ If employed, please state occupation ....
Self-employed ☐ Student ☐ Unemployed ☐ Retired ☐ Other ☐

Name of next of kin: ..... Tel. No. .....

Relationship to you:.....

Emergency contact no. (if different) .....

Are you a carer? Yes ☐ No ☐ Do you have a carer? ..... Yes ☐ No ☐

Please tick if you consent to receiving text messages (such as reminders) from the surgery ☐

Please tick if you wish to sign up for the online patient access service (appts & prescriptions) ☐

Personal and family history

What is your height?..... Weight? .....

Do **you** have any of the following? If "yes" please tick in the box and state the approximate date of diagnosis
Has any of your close **family** (mother, father, brother, sister, grandparent, uncle or aunt) suffered any of the following? If "yes" please tick the box

	You (when/year of onset)	**Family member** (Who)
Asthma		
Diabetes		
High blood pressure		
Stroke		
Cancer		
Epilepsy		
Depression		
Heart attacks/disease		If under 60 years old at time

Medications

Please list any medications that you take regularly:

.....

.....

Allergies

Are you allergic to any drugs or medications? If so, which ones? (Please list below)

.....

Women's health

Have you ever had a smear test? Yes ☐ No ☐ If YES, please give the approximate date …….

Lifestyle

Are you a smoker? Yes ☐ No ☐

If YES, how many cigarettes/ounces of tobacco a day? .....

If NO, have you ever smoked? Yes ☐ No ☐

If you used to smoke, what month and year did you give up smoking? ……..

How many cigarettes/ounces of tobacco a day did you smoke? ……..

Is your job physically active e.g. lifting heavy objects, building, stacking shelves?
Yes ☐ No ☐ I don't work ☐

Do you cycle/run/swim/play sports or do any physical exercise on a weekly basis?
No ☐ Yes ☐
if yes what exercise and how many times per week?.....

How often do you drink alcohol?
Never ☐ Monthly or less ☐ 2-4 times per month ☐ 2-3 times a week ☐ 4 or more times per week ☐

How many standard drinks (e.g. a small glass of wine, half pint of beer or single measure of spirit) containing alcohol do you have on a typical day?
1-2 ☐ 3or4 ☐ 5or6 ☐ 7-9 ☐ 10 or more ☐

How often do you have **6 or more** drinks on one occasion?

Never ☐ less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost every day ☐

Thank you for completing the questionnaire. All information will be dealt with in the strictest confidence.

Please sign …….. Date …….